**NEW PATIENT INTAKE**

**Date: \_\_\_\_\_\_\_\_\_\_**

**Name (F) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(M)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(L)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: M / F AGE:\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address, City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: Single / Married / Divorce / Widowed (circle one)**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance type: PPO POS HMO Deductible Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies: (Drug, Food, Environment) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Present Medical History**

**Spleen & Stomach**

* Stomach Pain
* Gas Fullness
* Heartburn
* Over Acids
* Nausea
* Vomiting
* Belching
* Indigestion
* Foul Breath
* Prolapsed
* Bruise(easily)
* Constipation
* Hemorrhoids
* Loose Stool
* Diarrhea
* Abdominal Distention
* Abdominal Pain or Cramps
* Fatigue
* Thirsty

Appetite: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Digestion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bowel Movement:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_times/day

**For Men**

* Prostate Infection
* Prostate cancer
* Enlarged Prostate
* Impotency

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lung**

* Cough
* Cough Blood
* Asthma
* Bronchitis
* Pneumonia
* Common Cold
* Loss of voice
* Sinus Problem
* Phlegm
* Depression
* Skin Problems
* Sore Throat
* Spontaneous Sweating
* Pain with deep Breath
* Difficulty in Breathing

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kidney**

* Ear Ringing
* Hearing Loss
* Hair Loss
* Lower Back Pain
* Knee Pain
* Joint Pain
* Edema (water Retention)
* Night Urination
* Decreased Sex Drive
* Incontinent
* Urination Problem:\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been treated for:**

**Heart**

* High Blood Pressure
* Low Blood Pressure
* Irregular Heartbeat
* Dizziness
* Chest Pain
* Night Sweating
* Insomnia
* Excessive Dreams
* Cold Hands or Feet
* Oversleep
* Swelling of hands or feet
* Palpitations
* Poor Memory
* Easily Awaken

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Liver**

* Easily Upset
* Headaches
* Facial Redness
* Easily Sigh
* Bitter Taste in mouth
* Pain in the Ribs
* Dizziness
* Twitching or Spasm of Muscles
* Brittle Nail
* Numbness
* Eye Problem

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* AIDS
* HIV+
* Hepatitis\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

* Stroke
* Diabetes
* Heart Disease
* High Blood Pressure
* Low Blood Pressure
* Arthritis
* Anemia
* Epilepsy
* Kidney Disease
* Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Asthma

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History**

(Parent, Grandparent,

 Sister / brother)

* Cancer
* Diabetes
* Heart Disease
* Seizures
* Stroke
* Asthma
* Hypertension
* Hypotension

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you taking any medication **Y / N** What kind ?

 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 7\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 9\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Use of alcohol:Never / Rarely / Moderate / Daily Use of Tobacco: Never / Rarely / Moderate / Current? Packs/day

Use of drugs: Never/Type/Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses ? When?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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CHIEF COMPLAINTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FOR WOMEN**

**Menstruation**

**Discharge**

* Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Menopause**

* Hot Flash
* Night sweating

**Pregnancy**

* Number of Pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Premature Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Abortion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* None (when stopped\_\_\_\_\_\_\_\_\_\_\_)
* Abdomen Pain
* Low Back Pain
* Breast Pain
* Excessive Amount
* Normal Amount
* Hot Flash
* Little Amount
* Clots
* Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Length of Periods \_\_\_\_\_\_days
* Length of each cycle \_\_\_ days

Other Symptoms:­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other symptom or Diagnoses:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Miscarriage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C-Section: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_